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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA, *Petitioner,*

v.

MARICOPA COUNTY MEDICAL SOCIETY, MARICOPA FOUNDATION FOR MEDICAL CARE, and PIMA FOUNDATION FOR MEDICAL CARE, *Respondents.*

On Writ of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE*

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BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE*

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association ("AHA") represents more than 6,300 health care institutions, including most of the nation's hospitals, long-term care institutions, mental health facilities and hospital schools of nursing. As such, AHA is intimately concerned with the ability of the nation's health delivery system to respond to demands for care in a cost-effective, competent and dependable manner.

Considerations of price, quality and availability of service are as much a part of the health delivery system as of any other marketplace. However, the nature, size and variants of the market participants in the health field distinguish it from other commercial marketplaces.

The juxtaposition of the system's participants, the frequently distorted incentives spawned by the third-party payment mechanism and by the nature and extent of demand, the needs of and for physicians to respond to that demand, and the impact of modern technology contribute to make the health delivery system one of several atypical and unusual markets.

In light of the mission of AHA members to serve the health care needs of the nation, and the importance of their succeeding in an unusual market, the American Hospital Association has a particular interest in the legal issues which surround that marketplace.

This interest is manifest in the desire of AHA to lend its support, not to seek special consideration for its field nor exemption from either the law or forces that govern everyone, but rather to reinforce the contention that issues relating to the health care marketplace should be examined on case-by-case basis — a Rule of Reason — rather than be governed by assumptions borrowed from other fields or growing out of experience and facts which are either nonexistent or yet unproven in the field of health delivery.

SUMMARY OF ARGUMENT

The health care delivery system is one of the unusual market situations for which it is necessary to make a careful examination of the attendant business relationships in order to assess the competitive impact of any particular conduct. The market in the health services industry differs significantly from the more common commercial marketplaces in which consumers are expected to make their purchases in response to differences in the price and quality of the available goods and services. Consumers of health care are patients who do not

generally make the same kinds of choices. The system of third-party reimbursement for health care and of favorable tax treatment for medical expenses dissipates the kind of incentive that is present in a typical commercial context where consumers shop for the highest quality at the lowest price. An additional problem for consumers of health services is their lack of adequate knowledge to fairly evaluate the need for treatment or the medical procedures to be used.

Because the competitive impact of conduct is dependent upon the nature of the industry within which the conduct occurs, the competitive effects of any particular conduct in the health care delivery system may differ significantly from the effects of similar conduct in a different type of marketplace. It is therefore important to note that while the establishment of maximum prices has been ruled upon when examined in the context of true commercial industries, the courts have not had enough experience with the type of conduct practiced by Respondents in establishing maximum reimbursement levels to know what effect this practice has on competition within the health care field.

Price competition is relatively new to the health care delivery system. How that unique system will react competitively to any specific conduct is as yet not conclusively determined. Application of the Rule of Reason standard of liability is therefore necessary to evaluate the conduct in question and to determine the competitive effect it has on the market in the health services industry.

ARGUMENT

I. Introduction

Respondent Foundations for Medical Care ("FMCs") established maximum levels of reimbursement that their physician members could claim as payment-in-

full for health services provided to policyholders of FMC-approved insurance plans. Petitioner requested, and was denied, summary judgment on the issue of Respondents' antitrust liability for this conduct.[1] The denial was proper because the conditions for summary judgment required by the Federal Rules of Civil Procedure ("Federal Rules")[2] have not been satisfied. The Federal Rules require that summary judgment be granted only in cases where (1) ". . . there is no genuine issue as to any material fact and [2] . . . the moving party is entitled to a judgment as a matter of law."[3] In the case at bar, these two criteria could be met only by concluding that Respondents' conduct was *per se* violative of the antitrust laws and that therefore no other facts relating to the disputed activity need be examined. Through this amicus brief, the American Hospital Association intends to reinforce the Respondents' contention that the lower courts were correct in denying summary judgment. Application to the facts of this case of a *per se* standard of illegality in the context of the health care delivery system is inappropriate and inconsistent with this Court's prior decisions.

II. The Competitive Impact Of Conduct Is Necessarily Affected By The Nature Of The Industry In Which The Conduct Occurs

Section 1 of the Sherman Act prohibits "every contract, combination . . . or conspiracy, in restraint of trade or commerce among the several states."[4] Because a

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[1] *Arizona* v. *Maricopa County Medical Soc'y*, 643 F.2d 533 (9th Cir. 1980), *cert. granted* 101 S. Ct. 1512 (1981).

[2] *See Fed. R. Civ. P.* 56(c).

[3] *Id.*

[4] 15 U.S.C. §1 (1976).

literal interpretation of this language would prohibit virtually any contract or agreement in the marketplace, this Court has held that only those agreements which "unreasonably" restrain trade are prohibited by the Act.[5] However, certain types of agreements have been identified as being so consistently unreasonable that they may be deemed to be illegal *per se*, without inquiry into their purported justification.[6]

> [T]here are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use.[7]

In order to assess whether conduct meets that criteria for application of the *per se* rule, *i.e.* a "pernicious effect on competition and lack of any redeeming virtue," this Court has held that the standard may be applied only after considerable experience with disputed business relationships.[8] This requirement cannot be satisfied by transposing the experience of relationships in one type of industry marketplace to another industry marketplace which is neither similar nor comparable in nature. Thus, the special characteristics of the particular marketplace must be examined in the process of evaluating the impact of any challenged conduct.

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[5] *See Northern Pac. Ry.* v. *United States*, 356 U.S. 1 (1958); *Chicago Board of Trade* v. *United States*, 246 U.S. 231 (1918); *Standard Oil Co.* v. *United States*, 221 U.S. 1 (1911).

[6] *See Northern Pac. Ry.* v. *United States*, 356 U.S. at 5 (1958); *Mackey* v. *National Football League*, 543 F.2d 606, 618 (8th Cir. 1976), *cert. dismissed* 434 U.S. 801 (1977).

[7] *Northern Pac. Ry.* v. *United States*, 356 U.S. at 5.

[8] *See Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 9 (1979); *United States* v. *Topco Associates, Inc.*, 405 U.S. 596, 607-608 (1972).

Contrary to petitioner's assertion,[9] it is proper and necessary to focus on the nature of the industry involved in disputed activity before deciding whether to apply the *per se* standard of illegality or to judge facts under the Rule of Reason. This Court thoroughly examined the nature of the industry involved in the case of *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*[10] before deciding that, under the circumstances inherent in the market for performing rights for copyrighted musical compositions, the blanket licenses at issue did not constitute price fixing *per se* unlawful under the antitrust laws.[11]

Similarly, in *Mackey* v. *National Football League* ("NFL"),[12] the Eighth Circuit rejected the District Court's finding that the NFL's Rozelle Rule ("Rule")[13] was a *per se* violation of the Sherman Act. The Court stated that the unusual circumstances of the case made it inappropriate to declare the Rule illegal *per se* without undertaking an inquiry into the purported justifications for it.[14] Although enforcement of the Rule allegedly constituted a group boycott and a concerted refusal to deal, it was necessary to test its validity under the Rule of Reason because "the unique nature of the business of professional football render[ed] it inappropriate to mechanically apply per se illegality rules. . . ."[15] Citing

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[9] *See* Brief for Petitioner at 16, filed June 5, 1981.

[10] 441 U.S. 1 (1979).

[11] *Id.*

[12] 543 F.2d 606 (8th Cir. 1976), *cert. dismissed* 434 U.S. 801 (1977).

[13] The Rozelle Rule is the NFL's rule which allows the league commissioner to require the club acquiring a free agent to compensate the free agent's former club.

[14] *Mackey* v. *National Football League*, 543 F.2d at 619.

[15] *Id.*

White Motor Co. v. *United States*,[16] in which this Court rejected the application of *per se* rules to vertically imposed territorial restrictions, the Eighth Circuit stated that "when faced with a unique or novel business situation, courts have eschewed a *per se* analysis in favor of an inquiry into the reasonableness of the restraint under the circumstances."[17]

In *Goldfarb* v. *Virginia State Bar*,[18] which involved minimum fee schedules established by a bar association, this Court unanimously concluded that the antitrust laws are applicable to professions.[19] However, there was language in *Goldfarb's* now famous footnote seventeen which has been interpreted to allow special treatment for professionals.[20] This language was later qualified in *National Society of Professional Engineers* v. *United States*,[21] a case in which this Court examined a section of the canon of ethics of the National Society of Professional Engineers that prohibited members from submitting competitive bids for engineering services. In *Professional Engineers*, this Court stated that footnote seven-

[16] 372 U.S. 253 (1963).

[17] *Mackey* v. *National Football League*, 543 F.2d at 619.

[18] 421 U.S. 773 (1975).

[19] *Id.* at 787.

[20] "The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently. We intimate no view on any other situation than the one with which we are confronted."

421 U.S. at 788 n.17.

[21] 435 U.S. 679 (1978).

teen in *Goldfarb* does not provide a broad exemption under the Rule of Reason for learned professions. However, the Court did not provide explicit guidance as to how restraints by professionals should be analyzed. The Court stated that the purpose of judicial analysis in antitrust cases is to form a judgment about the competitive significance of the restraint[22] and that the Rule of Reason analysis only permits procompetitive justifications. The Court did however adhere to the view expressed in *Goldfarb* that "by their nature, professional services may differ significantly from other business services, and accordingly, the nature of the competition in such services may vary."[23] It is significant that whatever else was at issue, this Court reinforced the fundamental notion that the competitive effects of conduct will differ depending on the context in which the activity occurs, or the nature of the industry in question. Without granting special treatment for professions, the *Professional Engineers* opinion expressly noted that the competitive impact of conduct may vary in different industries. This notion was reaffirmed in *Broadcast Music, Inc.*

III. The Unique Nature Of The Health Care Delivery System Distinguishes It From General Commercial Industries

The most significant question before this Court is whether *per se* rules of illegality may be applied to conduct within any industry which does not conform to the usual competitive mode of operation. It would be contrary to this Court's prior decisions to apply the *per se* standard of illegality to conduct, regardless of its characterization, when the conduct's effects on competition are unknown or inconclusive.

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[22] *Id.* at 692.

[23] *Id.* at 696.

The health care delivery system presents a unique market situation which deserves a thorough examination of all the facts in order to fairly judge the pro-competitive or anticompetitive effects of the Respondents' activities. For example, in *Virginia Academy of Clinical Psychologists* v. *Blue Shield*,[24] the Fourth Circuit refused to apply a *per se* rule of illegality to medical plans which refuse or condition payments to competing providers.[25] The refusal was based upon the inappropriateness of applying a *per se* standard to the special circumstances inherent in the delivery of health services.[26] The special circumstances present in the health care delivery system have resulted in a marketplace which has not functioned competitively in the classic sense.[27] This fact was recently considered by the Supreme Court in *National Gerimedical Hospital and Gerontology Center* v. *Blue Cross*,[28] in which the Court took special note of a 1974 report of the Committee on Labor and Public Welfare of the United States Senate which stated:

> In the view of the Committee, the health care industry does not respond to classic marketplace forces. The highly technical nature of medical ser-

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[24] 624 F.2d 476 (4th Cir. 1980).

[25] *Id.* at 484.

[26] *Id.* The Court refused to apply the *per se* standard even though the activity in question was characterized as a boycott, activity which is treated as a *per se* violation when encountered in a general commercial context. *Id.*

[27] Miller, *Antitrust and Certificate of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture*, 68 *Geo. L.J.* 873, 876 (1980) [hereinafter cited as *Miller*].

[28] No. 80-802 (Sup. Ct. June 15, 1981)(finding no implied antitrust immunity for the refusal of Blue Cross to grant participating status to National Gerimedical Hospital).

> vices together with the growth of third party reimbursement mechanisms act to attenuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures.[29]

The marketplace in which commodities and services are bought and sold is generally described as the typical commercial marketplace. Consumers in this market respond to differences in price and quality and will demand the highest quality at the lowest price. It follows that the buying responses of consumers determine which commodities will be widely produced and indirectly determine the prices at which they will be sold.

Unlike the environment of the typical commercial marketplace, patients (consumers in the health care industry) have generally not responded to changes in price of care, primarily because their health insurance coverage operates to remove price as a factor at the time of delivery of the service. In a 1980 article in *The Georgetown Law Journal,* Frances Miller cited examples of the health insurance benefits and favorable tax treatment for medical expenses which undercut financial incentives that might otherwise lead patients to economize on health care expenditures:

> For calendar year 1978, 67% of total personal health care expenditures in the United States were financed by some form of third-party payment. Pa-

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[29] *S. Rep. No.* 93-1285, 93d Cong., 2d Sess. 39, *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878; No. 80-802, *slip op.* at 8 (Sup. Ct. June 15, 1981).

> tients did not have to pay out-of-pocket for $112.6 billion of their health care costs. [citation omitted] Health insurance premiums are deductible business expenses. Treas. Reg. §162-10(a) (1975). Moreover, they are not taxed as income to employees. I.R.C. §106. . . . Individual taxpayers who do not receive health insurance benefits from employers, but purchase it directly from insurers, may deduct the first $150 of premiums paid from ordinary income. I.R.C. §213(a)(2). In addition personal medical expenses are deductible from ordinary income to the extent they exceed three percent of adjusted gross income. I.R.C. §213(a)(1).[30]

An additional disincentive to shop for the best price in health and medical care is the high degree of technological complexity involved in their delivery. Medical treatment frequently involves advanced scientific testing and evaluation and few consumers fully understand the differences in the objectives sought or the specific results to be achieved from various methods of treatment. Although cost is often directly related to the technological complexity of the diagnostic and treatment procedures pursued, the need and demand for innovative testing and treatment has resulted in a lessened concern for cost-benefit analysis. Both patients and physicians tend to prefer the more advanced form of treatment, normally believed to be the best, although more costly, alternative.[31] As a result of third-party reimbursement and patient naivete with respect to differences in methods of treatment, the customary effects of price on the marketplace do not occur in the delivery of health services.

In addition to the fact that consumers of health care services fail to respond to price, they also are unable to

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[30] *Miller, supra* note 27, at 877, n. 25.

[31] *See id.* at 877.

adequately respond to the quality or degree of treatment which they receive. Because of the general lack of information and knowledge on the part of consumers regarding the necessity for medical treatment or the type or extent of treatment needed, patients characteristically pursue and accept whatever treatment is recommended by their physician. Consequently, in the health care delivery system, there is no competitive marketplace in the form of a greater demand for the physicians who recommend less treatment at lower prices.

Role of foundations for medical care within the health care delivery system

In an environment which did not respond to normal competitive forces, Foundations for Medical Care were established to monitor the cost and quality of health care. FMCs are best described as corporations of physicians organized under state nonprofit statutes concerned with the quality and cost of medical care.[32]

> Common to all Foundations are three basic beliefs: physicians must retain responsibility and leadership in the design, administration, and delivery of medical services; medical care must be provided at a just and equitable cost to both patient and physician; and peer review conducted by medical society members must be encouraged as an efficient mechanism to insure quality care and to control the rise of medical costs. In addition, a primary function of most Foundations is preserving the traditional mode of rendering medical care-solo fee-for-service prac-

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[32] *See National Ass'n of Blue Shield Plans, Foundations for Medical Care* I-1 (1972) [hereinafter cited as *Foundations for Medical Care*]; C. Steinwald, *Foundations for Medical Care* 1 (*Blue Cross Reports*, Research Series 7, August 1971) [hereinafter cited as *Blue Cross Report*].

tice. Freedom of choice on the part of the physician and patient is stressed in these Foundations along with the necessity of guarding the time-honored physician/patient relationship.[33]

In an effort to achieve the goals of medical cost containment and quality medical care, each FMC establishes minimum standards of care and specific benefits which the Foundation determines to be crucial to the delivery of quality medical care in its area. The FMC then contracts with insurance companies and/or Blue Cross or Blue Shield Plans to underwrite and market this Foundation-sponsored program. Members of the FMC agree to accept the maximum fees that are set by the FMC and to be subject to peer and utilization review by the Foundation.

Comprehensive FMCs have two principal functions: to design and sponsor prepaid health insurance programs and to carry out peer review of the quality of health care. In evaluating the effectiveness of FMCs in carrying out these basic functions, a report published in 1973 stated: ". . . Comprehensive FMCs . . . have many years of experience with intensive peer review, which has produced important savings in medical costs with no decrease, and often appreciable increases, in quality of care." [34] The same author went on to state that comprehensive FMCs provide about the only responsible vehicle available whereby physicians can be reimbursed on a fee-for-service basis and at the same time participate in an organized, cost-effective, high quality health-care delivery system.[35]

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[33] *Blue Cross Report, supra* note 32, at 1.

[34] R. Egdahl, *Foundations for Medical Care*, 288 *New England J. Med.* 491, 493 (1973) [hereinafter cited as Egdahl].

[35] *Id.* at 495.

The Respondent Foundations were established to provide residents of Pima and Maricopa Counties with a competitive alternative to utilization of closed panel prepaid health insurance plans.[36] "The foundations' medical insurance programs provide a unique competitive alternative that directly promotes competition, with demonstrable benefits to insured patients."[37] Patients insured by the Respondent Foundations may be treated by any physician of their choice. If they choose a physician member of the Foundation, the patients are assured that their insurance will cover payment-in-full for their medical treatment. Should Foundation insureds receive treatment from nonmember physicians, the physician is paid the fee set by the FMC for the treatment given, and the physician may then bill the patient for the balance of his charge for the services rendered. This process provides the patient with a procompetitive incentive to shop for a physician who is a member of the Foundation or who does not charge more than the Foundation will pay.

The Respondent Foundations' establishment of maximum reimbursement levels is a critical component of the over-all purpose of the FMCs to provide prepaid health insurance programs and to monitor both the quality and cost of health care. Insurers rely on maximum reimbursement schedules in cost control programs,[38] as does the State of Arizona in determining appropriate

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[36] Joint Brief in Opposition to the State of Arizona's Petition for a Writ of Certiorari at 8, filed October 20, 1980 [hereinafter cited as Respondents' Joint Brief].

[37] *Id.*

[38] D. Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 *Duke L.J.* 645, 690 (1978) [hereinafter cited as Kallstrom]; Egdahl, *supra* note 34 at 492, 495.

payments to physicians in, *inter alia,* workmen's compensation cases.[39] In addition, maximum reimbursement schedules are currently used in approximately 25% of Blue Shield contracts.[40] In setting up a prepaid health-service activity,

> some type of control of payment to physicians is necessary, and since the comprehensive FMC is dedicated to the fee-for-service principle of reimbursement, no program can be actuarily sound without agreement by physicians on maximum fees coupled with appropriate peer review to prevent overutilization of treatments and procedures.[41]

Like the blanket license mechanism in *Broadcast Music,* the use of maximum reimbursement levels has provided an acceptable method for accomplishing the principal purposes of the FMCs over the years.[42]

Under the rule established by this Court in *Northern Pac. Ry.* v. *United States* and reaffirmed in *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.* this conduct should not be presumed *per se* violative of the Sherman Act unless there is a "universal view"[43] that the activity in question in anticompetitive without any redeeming virtue. There is no such consensus regarding the challenged conduct within the health care delivery

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[39] Respondents' Joint Brief, *supra* note 36, at 6.

[40] Bureau of Competition, Federal Trade Commission, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans,* Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule, at 128 (April 1979) [hereinafter cited as FTC Staff Report].

[41] Egdahl, *supra* note 34, at 492.

[42] *See* text accompanying notes 32-42, *supra.*

[43] *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.,* 441 U.S.1, 16 (1979).

system. Respondent Foundations argue that they provide a competitive alternative to closed panel prepaid health insurance plans. Whether the procompetitive aspects of their conduct offset the alleged potential anticompetitive impact is an issue of fact which has not yet been determined.

Across the health care delivery system, relationships not unlike those before the Court today are being examined. The results are inconclusive as to whether medical participation in health insurance plans is violative of the antitrust laws. For example, in April, 1979, the Bureau of Competition of the Federal Trade Commission issued a Staff Report and Proposed Trade Regulation Rule ("the Report") entitled *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans.* The Report provided an in-depth analysis of the Bureau of Competition's investigation into ". . . the extent, impact, and legality of medical participation in the control of Blue Shield and other open-panel medical prepayment plans."[44] The results of the investigation confirmed that physicians and physician organizations often control or influence Blue Shield decisions concerning reimbursement, cost-containment, and other matters affecting competition.[45] The investigation was conducted over a period of more than three years and studied activities involving physicians' influence upon the determination of appropriate reimbursement levels for Blue Shield plans. The conduct under investigation was similar and comparable to that of the FMCs which is before the Court today.

It is noteworthy that the 409-page Report and Proposed Rule were not adopted as an official Federal

[44] FTC Staff Report, *supra,* note 40, at 1.

[45] *Id.*

Trade Commission position. Instead, the Commission requested comments on the conclusions which ranged from a finding that certain activities contributed to the benefit of the public, to the conclusion that some forms of medical participation in the control of Blue Shield and other open-panel medical prepayment plans may constitute unfair methods of competition.[46] After receiving comments on the controversial Report and proposal to limit the control physicians or medical societies have over Blue Shield boards, the FTC recently abandoned plans to promulgate an industrywide rule on the matter.[47] Instead, the Commission will investigate complaints on a case-by-case basis. Because the results of the analysis were far from conclusive as to alleged potential anticompetitive effects of physician control over reimbursement decisions made by Blue Shield boards, the FTC plans to proceed selectively when examining these types of relationships, using the Rule of Reason approach that takes into account the share of the market possessed by a plan, the degree of physician participation in fee setting, the plan's coverage, and any other facts relevant to understanding the competitive effects of the activity in question.[48]

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[46] *Id.*, at 2, 4.

[47] *See* 46 Fed. Reg. 27768 (1981).

[48] *Id. See Michigan State Medical Society*, No. 9129 (FTC June 19, 1981). This is an initial decision in which the FTC relied on this Court's opinions in *National Society of Professional Engineers* v. *United States*, 435 U.S. 679 (1978), and *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773 (1975), as a basis for examining the alleged price-fixing and boycott agreements in dispute according to the Rule of Reason standard of illegality rather than holding them to be *per se* violative of the Sherman Act.

This recent FTC action is persuasive evidence of the inadequate level of knowledge regarding the health care delivery system and the competitive response of this unique industry to various types of business relationships, including those challenged in the case at bar.

IV. Because Of The Unique Nature Of The Health Care Delivery System, The Challenged Activity Should Be Judged According To The Rule Of Reason Standard Of Liability Rather Than According To The Per Se Standard

Courts need considerable experience in evaluating the competitive effects of business relationships in the health care delivery system before the *per se* standard of illegality may be applied.[49] For this reason, the Court should avoid adopting a characterization developed in other commercial contexts for conduct whose competitive effects in the health services industry are inconclusive. Because the inquiry under the Rule of Reason focuses on the competitive impact of conduct, the Rule of Reason is the standard to be applied when the competitive effects of activity in question are unknown.

There is no dispute as to the fact that in the strict commercial context, agreements to fix prices have been held illegal *per se*.[50] The same is true of agreements to

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[49] *See Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36, 50 (1977); *United States* v. *Topco Associates, Inc.*, 405 U.S. 596, 607 (1972); *White Motor Co.* v. *United States*, 372 U.S. 253, 263 (1963).

[50] *See United States* v. *McKesson and Robbins, Inc.*, 351 U.S. 305 (1956) (manufacturer/wholesaler agreed with independent wholesalers on prices to be charged on products it manufactured); *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940) (firms controlling a substantial part of an industry agreed to purchase

set maximum resale prices in the general commercial field.[51] However, not every agreement which literally determines a price is "price fixing" for purposes of employing the *per se* standard of illegality under the Sherman Act.[52] This Court stated in *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.* that ". . . easy labels do not always supply ready answers" and that a

> . . . literal aproach does not alone establish that this particular practice is one of those types [to which the per se rule has been held applicable] or that it is "plainly anticompetitive" and very likely without "redeeming virtue."
>
> Literalness is overly simplistic and often overbroad. . . . Thus, it is necessary to characterize the challenged conduct as falling within or without that category of behavior to which we apply the label "per se price fixing." That will often, but not always be a simple matter. [Citations omitted].
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> Consequently, as we recognized in *United States* v. *Topco Associates, Inc.*, 405 U.S. 596, 607-608 (1972), "[i]t is only after considerable experience with certain business relationships that courts classify them as per se violations. . . ."[53]

In *Broadcast Music,* this Court faced the question of whether the issuance by the American Society of

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"surplus" gasoline with the intent and necessary effect of increasing the price); *United States* v. *Trenton Potteries Co.*, 273 U.S. 392 (1927) (manufacturers and distributors of 83% of certain vitreous pottery fixtures agreed to sell at uniform prices).

[51] *See Kiefer-Stewart Co.* v. *Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951).

[52] *Broadcast Music, Inc.*, v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 8-9 (1979).

[53] *Id.*

Composers, Authors and Publishers (ASCAP) and Broadcast Music, Inc. (BMI) to CBS of blanket licenses to copyrighted musical compositions at fees negotiated by them was illegal price fixing as a *per se* violation of the Sherman Act. The Court held that the issuance of the blanket licenses did not constitute price fixing *per se* unlawful under the antitrust laws.[54] While noting that there have been cases holding various licensing practices to be violative of the Sherman Act, this Court found that there was no universal view that the use of the type of license in question (although at established prices) was a form of price fixing subject to automatic *per se* condemnation under the Sherman Act.[55] In so holding, the Court relied on the fact that the blanket license was not merely a naked restraint of trade which had no purpose beyond the stifling of competition.[56] The Court determined that the license in question was a "necessary consequence of the integration necessary to achieve [the efficiencies sought by their use], and a necessary consequence of an aggregate license is that its price must be established."[57]

Only by thoroughly examining all the relevant facts in a case such as the case at bar and *Broadcast Music* can the Court determine whether the conduct at issue violates the Sherman Act. Like the situation facing the Court in *Broadcast Music*, the activity presently before the Court is not at all a naked restraint with no purpose beyond the stifling of competition. The challenged con-

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[54] *Id.* at 24.

[55] *Id.* at 16.

[56] *Id.* at 20 (citing *White Motor Co.* v. *United States*, 372 U.S. 253, 263 (1963)).

[57] *Id.* at 21.

duct is an integral component of the over-all purpose of the FMCs to provide prepaid health insurance programs and to monitor both the quality and cost of health care. As such, ". . . when attacked, it should be subjected to a discriminating examination under the rule of reason. It may not ultimately survive that attack, but that is not the issue before us today."[58]

Petitioner relies on this Court's statement in *Catalano, Inc.* v. *Target Sales, Inc.*,[59] that: "It has long been settled that an agreement to fix prices is unlawful *per se.* It is no excuse that the prices fixed are themselves reasonable."[60] This statement by the Court is not inconsistent with the decision in *Broadcast Music* which recognized the need to have knowledge of the nature of an industry before applying the *per se* standard to conduct within that industry, regardless of whether the conduct could be categorized as that which appears to fit the broad label of "price fixing" or any other characterization.[61] *Catalano* involved general commercial activity with no special circumstances such as those inherent in the health care delivery system. There were no distinct characteristics of the industry in question in *Catalano* which warranted "a more discriminating examination under the rule of reason."[62] The unique

[58] *Id.* at 24.

[59] 446 U.S. 643 (1980).

[60] *Id.* at 647.

[61] *See also Mackey* v. *National Football League*, 543 F.2d 606, 618 (8th Cir. 1976), *cert. dismissed* 434 U.S. 801 (1977); *Virginia Academy of Clinical Psychologists* v. *Blue Shield*, 624 F.2d 476 (4th Cir. 1980).

[62] *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 24 (1979). This language was used by the Court to define the standard of illegality by which the conduct in question must be judged. *Id.*

nature of the health care delivery system does, however, warrant such an examination of conduct within its realm. The issue is not whether the disputed conduct was reasonable, but rather whether the conduct can be fully and fairly evaluated to determine whether it was reasonable in the context in which it occurred. A decision allowing such an examination is fully consistent with the decisions in both *Catalano* and *Broadcast Music*. In fact, a decision otherwise would be inconsistent with prior opinions because it would brand as illegal *per se* conduct whose competitive effects are as yet unknown.[63]

[63] *See* 46 Fed. Reg. 27768-69 (1981). The FTC reported its conclusion that medical control of prepayment plans is not always anticompetitive and therefore an analysis of the competitive impact of such conduct should include consideration of all relevant facts.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the judgment of the Court of Appeals should be affirmed. The activities of Respondent FMCs should be evaluated according to the Rule of Reason standard of illegality rather than be classified as *per se* violative of the Sherman Act.

Respectfully submitted,

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